STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for a State Residential Licensure Survey. Survey dates: October 15,16, and 17, 2013 Facility number: 003984 Provider number: 003984 Aim number: N/A Survey team: Patti, Allen, SW-TC Marcy Smith, RN Census bed type: Residential: 26 Total: 26 Census payor type: Other: 26 Total: 26 Residential sample: 7 These State Residential Findings are cited in accordance with 410 IAC 16.2. Quality review completed on October 22, 2013; by Kimberly Perigo, RN.	R000000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000055	410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on observation, record review, and interview, the facility failed to ensure a resident's privacy was maintained during an insulin injection for 1 of 1 insulin injections observed. This had the potential to affect 2 residents in the facility who received insulin injections. (Resident #1) Findings include: The clinical record of Resident #1 was reviewed on 10/15/13 at 12:40 p.m. Diagnoses for Resident #1 included, but were not limited to dementia and insulin dependent diabetes mellitus. During an observation of sliding scale insulin administration on 10/16/13 at 11:50 a.m., Licensed Practical Nurse (LPN) #1 removed Resident #1, in her wheelchair, from the dining room. She took the Resident to the corner of 2 hallways, approximately 20 feet from the west entrance to the dining	R000055	Citation # 1 R 055 410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights – Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? LPN #1 received written disciplinary counseling and was reeducated to our policy regarding maintaining residents' privacy while administering insulin. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Residence Director reviewed community practices regarding maintaining resident privacy during the administration of insulin injections, as well as other personal care or treatments. Licensed nursing staff were re-educated on maintaining resident privacy during the administration of insulin injections. New licensed staff will also be educated to the above upon hire. What measures will be put into place or what systemic changes will the facility make to	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room. She told Resident #1 she was going to give her insulin, pulled the waist band of the Resident's pants down approximately 2 inches, and pulled her shirt up approximately 2 inches, exposing the residents bare stomach. She then injected the Resident's insulin into her exposed stomach, while in the hallway. During an interview with the Wellness Director on 10/16/13 at 3:00 p.m., she indicated residents receiving insulin injections should be taken to their room or into a restroom for privacy. During an interview with the Residence Director on 10/17/13 at 10:00 a.m., she indicated LPN #1 had already received inservice training this morning regarding maintaining residents' privacy while injecting insulin.		ensure that the deficient practice does not recur? The staff were re-educated to the Indiana State regulation R 055 410 IAC 16.2-5-1.2(y) (1-4) Resident Rights and our policy and procedure regarding maintaining resident privacy. The Residence Director and/or Designee will be responsible for ensuring resident privacy is maintained during the administration of insulin injections. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Residence Director and/or Designee will be responsible for monitoring resident privacy while injecting insulin through weekly rounds of the community to ensure continued compliance with the above referenced regulation for a period of (6) six months. Rounds will be completed randomly, across all shifts and including weekends. Findings will be reviewed and corrected through the Worthington house QA process. A Quality Assurance meeting will be held after (6) six months to determine the need for the ongoing monitoring plan. Findings suggestive of compliance result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon results of random reviews that indicate no additional areas of concern concerning the above	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			referenced regulatory criteria. The Regional Director of Quality and Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 11/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000144	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain clean resident apartments for 2 of 8 resident apartments. The uncleanliness of apartments affected Resident #3 and #20. Findings Include: Environmental tour was done on 10/17/13 at 10:45 a.m., with the facility Maintenance Service Director and Resident Director with the following observations: 1. In Resident #3's apartment, the carpet throughout the apartment was soiled and had multitude of stains, in a multitude of sizes; starting at the apartment entrance door. One resident occupied this apartment. 2. In Resident #20's apartment, there was a narrow path that lead to the Resident's bed. The carpet that was visible was soiled and had stains blackish/gray in color. The floor was covered with papers, books, clothes, totes, and boxes approximately 3 feet high around the room. The rest room	R000144	Citation #2 R 144 410 IAC 16.2-5-1.5 (a) Sanitation and Safety Standards - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #3's carpet was professionally cleaned. Resident #20 has a history of "hoarding behavior". The Residence Director met with the family of Resident #20 to discuss the uncleanliness of the apartment. Resident #20 will move to a new apartment within the residence. The Residence Director and the National Director of Resident Life Enrichment are currently revising an appropriate plan of care regarding Resident # 20's history of such behavior. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Residence Director conducted rounds of the Residence to ensure compliance with R 144 410IAC 16.2-5-1.5(a). No residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had clothes, papers, books, boxes, totes, and other items. The shelf in the closet had stuff stacked up to it and on it, almost to the ceiling. The furniture, window sill, and counter were covered with the same type of items. There was an accumulation of dirt and dust on these items throughout the apartment. Interview with the Resident at time of tour of the apartment. She indicated her dresser was full and could not hold any other clothes. Housekeeper comes in and cleans around her stuff. One resident occupied this apartment. In an interview with the Resident Director after environmental tour on 10-17-13, she indicated she was aware of the concerns found in Resident # 20's apartment and has been working with the family and resident for the past several months. In an interview with the housekeeper after environmental tour on 10-17-13, she indicated Resident #20's apartment has been piled up since she started working in July of 2013. She is not able to clean the apartment as needed. .		does not recur? The Residence Director was re-educated by the National Director of Resident Life Enrichment on lifelong hoarding. The staff has been re-educated to report uncleanliness of any resident apartment and/or carpet stains. A carpet cleaning schedule will be put into place. The Residence Director and/ or Designee are responsible to ensure resident apartments are in a state of good repair to ensure compliance with Indiana State regulation R144 410 IAC 16.2-5-1.5(a). How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Residence Director and/or Designee will perform random weekly audits of carpet sanitation in resident's apartments using the QA audit for Housekeeping to ensure continued compliance for a period of (6) six months. The Residence Director and/or Designee will perform random weekly audits of Resident #20's apartment using the QA audit for Housekeeping to ensure continued compliance for a period of (6) six months. Findings will be reviewed and corrected through the Worthington House QA process. A Quality Assurance meeting will be held after (6) six months to determine the need for the ongoing monitoring plan. Findings suggestive of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			compliance result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon results of random reviews that indicate no additional areas of concern concerning the above referenced regulatory criteria. The Regional Director of Operations and/or Designee will complete Quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 11/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented regarding physician notification for 1 of 7 records reviewed for completeness and accuracy of documentation in a sample of 7. (Resident #1) Findings include: The clinical record of Resident #1 was reviewed 10/15/13 at 12:40 p.m. Diagnoses for Resident #1 included, but were not limited to insulin dependent diabetes mellitus and dementia. A recapitulated physician's order for October, 2013, with an original date of 6/20/11, indicated Resident #1 was to receive accuchecks 3 times per day at 7:00 a.m., 11:30 a.m., and 4:00 p.m. An accucheck is a finger	R000349	Citation #3 R 349 410 IAC 16.2-5-8. 1(a)(1-4) Clinical Records – Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? When Resident #1's blood sugar is outside of physician ordered call parameters, licensed nursing staff will document the physician notification in the resident's clinical record. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Wellness Director conducted a review of the clinical records of residents receiving insulin to ensure records were complete and accurately documented pertaining to physician notification of blood sugars outside of call parameters. No other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	stick blood test done to measure blood sugars. A recapitulated physician's order for October, 2013, with an original date of 7/1/12, indicated the physician was to be notified if Resident #1's accucheck results were less than 80 or over 400. Medication Administration Records (MAR) for September, 2013, indicated the following regarding Resident #1's accucheck results: 9/2/13 11:30 a.m. blood sugar = 70 9/9/13 4:00 p.m. blood sugar = 71 9/15/13 4:00 p.m. blood sugar = 74 9/16/13 4:00 p.m. blood sugar = 74 9/17/13 4:00 p.m. blood sugar = 55 9/25/13 4:00 p.m. blood sugar = 70 9/26/13 4:00 p.m. blood sugar = 60 9/29/13 4:00 p.m. blood sugar = 71. MAR's for August, 2013, indicated the following regarding Resident #1's accuchecks: 8/1/13 4:00 p.m. blood sugar = 73 8/14/13 4:00 p.m. blood sugar = 64 8/15/13 4:00 p.m. blood sugar = 77 8/21/13 4:00 p.m. blood sugar = 60 8/23/13 4:00 p.m. blood sugar = 75 8/24/13 4:00 p.m. blood sugar = 57 8/26/13 4:00 p.m. blood sugar = 61		Licensed Nursing Staff were in-serviced on documentation regarding physician notification. Education regarding proper documentation of physician notification will be provided to new licensed nursing staff upon hire to Worthington House. The Residence Director and/or Designee will be responsible for ensuring clinical records are complete and accurately documented regarding physician notification to ensure compliance with Indiana State regulation R349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designee will perform weekly audits of the Medication Administration Record for accucheck results outside of call parameters and appropriate documentation of physician notification regarding these results to ensure continued compliance for a period of (6) six months. Findings will be reviewed through the Worthington House QA process after (6) six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon the results of random reviews that indicate no additional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/30/16 4:00 p.m. blood sugar = 61. No documentation was found in Resident #1's record to indicate the physician had been notified, regarding the above blood sugars below 80. During an interview with the Wellness Director on 10/16/13 at 10:00 a.m., further information was requested regarding whether or not the physician had been notified of Resident #1's September and August, 2013, blood sugars outside of call parameters. The Wellness Director indicated at that time, "We chart by exception." She indicated the nurses may have notified the physician and just not documented it.		areas of concern concerning the above referenced regulatory criteria. The Regional Director of Quality and Care Management and/or Designee will also perform quarterly random on site reviews of the Medication Administration Records / Clinical records to ensure continued compliance. By what date will the systemic changes be completed? 11/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000414	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure staff washed their hands before or after donning and removing gloves and administering eye drops and insulin. This had the potential to affect 26 of 26 residents residing in the facility. Findings include: During an observation of medication pass on 10/16/13 at 11:30 a.m., Licensed Practical Nurse (LPN) #1 applied sanitizer to her hands, gave a medication to Resident #3, applied sanitizer to her hands, gave a medication to Resident #9, then donned gloves, administered eye drops to Resident #9, removed her gloves, applied sanitizer, gave medication to Resident #20, applied sanitizer, gave Resident #24 medications, applied sanitizer, applied gloves, gave insulin to Resident #1, removed gloves and applied sanitizer. At no time during this sequence of events was LPN #1 observed to wash her hands.	R000414	Citation #4 R 414 410 IAC 16.2-5-12(k) Infection Control - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Licensed Practical Nurse (LPN) #1 was re-educated on our policy and procedure Preventing Transmission of Infection. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director observed the licensed nursing staff during a medication pass using the "Medication Pass Competency Checklist" and found them to be in compliance. No other residents were affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The licensed nursing staff were re-educated to the Indiana State ruling R 414 IAC 16.2-5-12(k) Infection Control and our policy and procedure on Preventing Transmission of Infection. Education on the above will be provided to new licensed nursing staff upon hire to Worthington House. The Residence Director	11/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A facility policy, titled, "Preventing Transmission of Infection," dated 1/1/13, received from the Residence Director on 10/15/13 at 3:00 p.m., indicated, "...II. Staff should always thoroughly wash their hands in the following situations:..After any possible contact with blood or other body fluids, even if wearing gloves;...after removing gloves;..." During an interview with the Wellness Director on 10/16/13 at 3:00 p.m., she indicated, "Nurses should wash their hands after removing gloves."		and/or Designee will be responsible to ensure compliance with the above referenced regulation. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Residence Director and/or Designee will conduct weekly audits of medication pass looking for proper hand washing techniques to ensure continued compliance for a period of (6) six months. These rounds will be completed randomly, across all shifts, including weekends. Findings will be reviewed through the Worthington House QA process after (6) six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon results of random reviews that indicate no additional areas of concern concerning the above referenced regulatory criteria. The Regional Director of Quality and Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 11/30/2013	